LETTERS *to the Editor*

Carpal Tunnel Syndrome

To the Editor: Doctors Doyle and Carroll in Volume 108, No. 4 very well cover the carpal tunnel syndrome, bring it to the attention of some still unaware of the entity, and present details of pathogenesis and etiology which are of interest to those who practice surgery of the hand as an implement of the adjacent extremity.

The editorial "Nerve Entrapment in the Upper Extremity" beautifully complements their essay and points out the obvious fact that nerve compression, or irritation, from the cervical cord distally, must be fully considered prior to a firm diagnosis of carpal tunnel syndrome.

The purpose of my letter relates to one phase of the matter which is mentioned under Conservative Treatment in the paper of Doctors Doyle and Carroll.

A steroid suspension may be injected without harm, and often with curative effect, in many locations. One who performs extremity surgery often sees the chalk-like plaques which are the residue of these injections. Apparently the material does little or no damage in tendons, tendon sheaths, bursae and ganglions.

This is not true in a nerve trunk. The residual steroid material is a foreign body and must interrupt continuity of neurofibrils if introduced into a nerve, very likely in greater degree than the underlying compression within the carpal tunnel.

This has long concerned me, and I do not think that even the most experienced can with certainty inject hydrocortisone into the carpal tunnel around but not into the median nerve, and I strongly feel that this approach to management of the carpal tunnel syndrome should be abandoned.

This opinion is emphasized by a case currently under my care. The patient, a 50 year old woman, developed right wrist pain and paresthesias over the median distribution attributed to repetitious use of the member at her work. She was seen in an adjacent medical facility and was given injections of "cortisone" into the wrist on three occasions but without relief.

Two months or so later she was referred to a competent orthopedist. An electromyogram was done, and she was given an injection of "cortisone" into the wrist, again without benefit.

The diagnosis of advanced median nerve alteration within the carpal tunnel was quite evident at the time that I first saw her. There was hypoesthesia over the median distribution and an "electric" feeling on pressure over the carpal tunnel. There was pronounced atrophy of the thenar eminence. Exploration of the median nerve, with unroofing of the carpal tunnel, was strongly indicated.

Dissection showed the presence of chalky white material entirely within the sheath of the nerve and apparently occupying 50 percent or more of the nerve trunk. There was no means of removing this other than by resection of the nerve, and this did not seem warranted at the time of surgery.

Three months following operation the patient has improved somewhat, but it is obvious that a good result will not be obtained, and one wonders if resection and anastomosis of the infiltrated segment of the nerve would not have been a better approach.

ROBERT J. MOES, M.D.
1930 Wilshire Blvd.
Los Angeles, Calif. 90057

Dissent

To the Editor: Please allow me to express my disagreement and disapproval of the editorial "The Baby and the Bath Water," Cal. Med., April 1968. The basic tenet on which Medi-Cal is founded is

the right (?) of all to receive medical care of equal quality, regardless of the ability to pay for such care. This makes no more sense than to propose all children need a quality diet and, therefore, have the public trough provide steak and eggs for all.

If we believe in the American system, we should extend charity to those in need and not ask the state to foot the bill. We should, indeed, "throw the baby out with the bath water," if this means nonparticipation in a system that invites fraud, deception and outright dishonesty.

FRED L. GREER, M.D.
Whittier, California

Student Loan Fund

To the Editor: Enclosed [following] is a letter in reply to an inquiry regarding the status of the [American Medical Association] student loan fund, of which I have felt, and continue to feel has been an excellent program for physician contribution. In this way an unmet need has been completed.

The tenor of the reply indicates the nature of the inquiry and I thought the reply a most interesting one and an excellent record of both help and recovery. I am forwarding a copy of the letter to you, insofar as you might like to insert this as an item of interest in CALIFORNIA MEDICINE to further encourage contributions by California physicians. I thank you in advance for your courtesy.

ROBERT L. GARRETT, M.D.
Vallejo, California

DEAR DOCTOR GARRETT:

Your letter to Doctor Blasingame dated March 27 in re the Student Loan Guarantee Program has been referred to me for answering. We appreciate your inquiry, and I am glad to provide you information about the status of pay out of loans.

The October 25, 1967 Report to the Board of Directors of AMA-ERF showed that we had 25,189 open interim notes, that is, active loans by medical students, interns and residents which were not yet in pay out status. At that time, we had 3,729 notes that were in pay out status. Of this number, 144 were delinquent.

32 deaths	17 military
38 slow payment	7 health
20 drop outs	12 other
18 bankruptcies	

On a gross figure basis, this would indicate under 4% of borrowers, who were in pay out status, were delinquent. However, recovery from estates in the case of death, eventual payment by those who are slow payers or drop outs, anticipated repayment by those in military, show us in a position where we will have a very small net loss.

I think you will see by this that our experience in the program has been and continues to be very good.

RICHARD M. NELSON
Director, Program Development
American Medical Association

THUMB OPHTHALMODYNAMOMETRY

"You always carry an ophthalmoscope, but you don't always carry an ophthalmodynamometer. If you are doing ophthalmoscopy in patients with fairly severe disease, just press in a bit with the thumb holding up the upper lid. If you see that artery begin to wink at you, you had better suspect that you will have a low ophthalmodynamometer reading."

—DAVID L. KNOX, M.D., Baltimore
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